Nursing Home Services
Part Y

Table of Contents

A. Type of Handbook

Part Y, Nursing Home Services, is the service-specific portion of the Wisconsin Medicaid Provider Handbook. Part Y includes information on provider eligibility criteria, recipient eligibility criteria, covered services, reimbursement and billing instructions. Use Part Y in conjunction with Part A of the Wisconsin Medicaid Provider Handbook which has general policy guidelines, regulations, and billing information for all providers certified in Wisconsin Medicaid. Nursing homes should use Part N of the provider handbook which contains the information on Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS), including covered services and prior authorization for specialized wheelchairs, respiratory equipment, and exceptional supplies for nursing home recipients.

Note: This handbook has references to various organizational units of the Department of Health and Social Services (DHSS), Division of Health (DOH), Bureau of Health Care Financing (BHCF). The DHSS is the designated single state agency for administration of the Medicaid program in Wisconsin; and the BHCF is the designated State Medicaid Agency for overall program administration. A copy of a current organization chart is available upon request.

B. Provider Information

Nursing Homes - General Definitions

Nursing home is defined in Chapter 50, Wis. Statutes, as: "a place which provides 24-hour services including board and room to three or more unrelated residents who because of their mental or physical condition require nursing care or personal care in excess of seven hours a week." Nursing homes participating in Medicaid are called nursing facilities (NFs). Nursing homes which also participate in Medicare are called skilled nursing facilities (SNFs). Facilities, or their distinct parts, which predominantly serve the developmentally disabled are called intermediate care facilities for the mentally retarded (ICF-MRs) or facilities for the developmentally disabled (FDDs).

Provider Eligibility and Certification

Wisconsin Medicaid certifies nursing homes to provide skilled and intermediate care. Under Wisconsin Medicaid, all NFs, ICF-MRs, or FDDs must be licensed according to s. 50.03, Wis. Stats. by the Bureau of Quality Compliance (BQC) in the Department of Health and Social Services (DHSS). Additional Medicaid certification requirements are:

1. SNFs which are also certified as an NF must meet the requirements for participation in Medicare as well as those specifically stated in HSS 105.08, 105.09, and 132, Wis. Admin. Code. These Medicaid requirements include the Medicare bed requirements defined in ss. 49.45(10) and 50.02(2), Wis. Stats.
2. ICF-MRs providing services to the developmentally disabled must meet the certification requirements stated in HSS 105.12 and 134, Wis. Admin. Code.

Providers interested in certification requirements specific to NFs or FDDs should contact the BQC. Refer to Appendix 22 of this handbook for the BQC addresses, including district offices.

Scope of Service

The policies in Part Y govern services provided within the scope of the practice of the profession as defined in s. 50.01, Wis. Stats., s. 49.45(6m), Wis. Stats. and HSS 107.09, Wis. Admin. Code. Covered services and related limitations are addressed in Section II of this handbook.

B. Provider Information (continued)

Nursing Home Reimbursement

Medicaid-certified nursing homes are reimbursed according to a prospective rate-setting methodology as stipulated in s. 49.45(6m), Wis. Stats. The DHSS establishes this methodology annually. The methodology is called "the formula" or "the Methods of Implementation." The payment formula determines nursing home payment rates for the annual rate year (defined as July 1 through June 30 of each year). The formula is annually transmitted to certified nursing homes by the Bureau of Health Care Financing (BHCF). For rate setting, nursing homes must complete an annual cost report which corresponds to the individual nursing home's fiscal year. In addition, nursing homes must provide other information on the annual formula to determine the actual payment rates.

Generally, the individual nursing home's payment rate from Wisconsin Medicaid is based on the nursing home's allowable costs during the previous 12-month fiscal year period, increased by a projected inflation percentage for the effective rate period (current year), and limited by the nursing home formula parameters. Nursing homes are required to annually submit a twelve-month cost report, and the payment formula is part of the Medicaid State Plan referred to as the annual Methods of Implementation. Medicaid regional auditors set the rates. The addresses of the regional auditors are listed in Appendix 21. Questions regarding the actual payment formula should be directed to the Nursing Home Section of the BHCF.

Separate accommodation rates are established for each level of care (medical intensive skilled, head injury skilled, skilled, intermediate nursing care levels and developmentally disabled care levels). A list of the accommodation codes, including bedhold codes, is in Appendix 15 of this handbook. The following Medicaid accommodation codes and their corresponding nursing home care levels are as follows:

Accommodation Code	*Care Level*
20	Skilled Care
21	Intermediate Care 1 and Intermediate Care 2-Limited
22	Intermediate Care 3-Personal
23	Intermediate Care 4-Residential
25	Intensive Skilled Nursing
26	Developmentally Disabled 1A
27	Developmentally Disabled 1B
28	Developmentally Disabled 2
29	Developmentally Disabled 3
80	Brain Injured (Prior Authorization Required-See Section III)

Intermediate care level three (personal) and care level four (residential) are not reimbursable except for:

- residents who entered a facility before October 1, 1981, and have continuously resided in a health care facility since that date; and
- residents who have a primary diagnosis of developmental disabilities (DD) or chronic mental illness (CMI) and who entered a facility before November 1, 1983, and continuously resided in a nursing home.

B. Provider Information (continued)

Nursing Home Appeals Mechanism

A nursing home appeals mechanism exists under Section 49.45 (6m)(e) of the Wisconsin Statutes. Called the "Nursing Home Appeals Board," its purpose is to review applications from nursing homes for financial relief if demonstrated, substantial inequities exist in the individual nursing home Medicaid rates resulting from the annual nursing home payment formula. The Statute lists various criteria which may qualify a nursing home for appeals mechanism funding.

The Nursing Home Appeals Board is separate from the Chapter 227 administrative hearing process and the Administrative Review Process (below) which both address Wisconsin Medicaid rate decisions. The Appeals Board functions retrospectively following the completion of the rate year. Nursing homes interested in this mechanism must submit a 12-month cost report coinciding with the formula rate year along with an appeal application.

Nursing homes are annually notified through a BHCF Memorandum when the appeal requests are due. Additional information can be obtained by contacting the Wisconsin Medicaid Nursing Home Appeals Auditor, Nursing Home Section, BHCF.

Administrative Review Process

The BHCF has established an administrative review process for nursing home rates calculated by the BHCF regional auditors. This process is different from the formal administrative hearing process described in Chapter 227, Wis. Stats., and from the nursing home appeals mechanism which addresses payment formula inequities.

The purpose of the administrative review process is twofold. The first is to allow nursing homes a vehicle to contest interpretations by Medicaid regional auditors when setting Medicaid nursing home payment rates. According to the Nursing Home Methods of Implementation, a nursing home may request an administrative review of the DHSS' cost finding decisions in the rate-setting process. For example, this could mean a disputed adjustment by the Auditor to costs reported in the annual cost report. The request must be filed within 30 days of the facility's receipt of notification of the Medicaid nursing home proposed rates.

The second purpose of the administrative review process is to develop payment policies and formula interpretations which may be initiated by the BHCF or which may be requested by nursing home providers or their representatives.

The administrative review process uses a review committee composed of the BHCF Nursing Home Section's Chief, one of the Section's Financial Supervisors and the Section's Review Auditor. A staff person from the Nursing Home Section's Policy staff is included in the Administrative Review Process for policy or payment formula interpretations and coordination. The assigned auditor may also be involved in instances of cost finding, allowable cost determinations, or rate disputes. The Administrative Review Committee meets whenever there are rate-setting interpretation requests to review or payment policy/formula interpretations to develop. The committee's decisions are subject to review and approval by the Director of the BHCF.

Requests from nursing homes for Medicaid Auditor interpretations or for policy/formula statements/interpretations may be requested through one of the nursing home associations for represented homes. The association provides initial screening and assists in the review process by assuring valid, complete and adequate requests, including combining multiple requests of a similar nature (i.e. several nursing homes with the same type of request). A nursing home may, also, submit a request directly to the Review Committee through the BHCF Nursing Home Section Chief.

B. Provider Information (continued)

Requests should contain specific data and factual information for consideration and not provide only generalizations. Requests contesting Medicaid Auditor interpretations must also be timely for consideration (within 30 days of the nursing home's receipt of notification of Medicaid rates).

For requested reviews contesting Medicaid Auditor interpretations in rate setting, the request must be submitted within the 30-day time frame; and a decision on the request will be submitted to the association and/or nursing home following the Committee's review and BHCF Director's approval (unless delegated). For payment policy or formal interpretation requested by nursing homes, the Committee will determine whether a policy statement is necessary.

For payment policy and/or formula interpretation development initiated by BHCF or by the Review Committee, a policy statement is drafted and reviewed by BHCF and then submitted to the nursing home associations and the Board on Aging and Long Term Care (BOALTC) for review and comment. The policy statement will include a preliminary recommendation. The associations and BOALTC have 10 working days to respond indicating either concurrence with the preliminary recommendation or factual and documented disagreement along with an alternative preliminary recommendation. An opportunity to present such a statement to the Review Committee may also be requested. Payment policy statements and/or formula interpretations will be coordinated by one of the Section's Financial Supervisors and a Nursing Home Policy Staff person.

Policy statements will constitute a nursing home formula policy manual and copies of the manual or various policy statements will be available to the industry and consumer advocacy agencies following final approval by the BHCF Director or a designee.

Administrative review request form instructions and the Nursing Home Rate Administrative Review Request form are included in Appendices 11 and 12 of this handbook. Nursing homes must complete this form to qualify for review.

Provider Responsibilities

Specific responsibilities as Medicaid providers are stated in Section IV of Part A of the provider handbook. Reference Section IV for detailed information on fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. Recipient Information

Eligibility For Wisconsin Medicaid

Eligible recipients for Wisconsin Medicaid are issued identification cards. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code, and an indicator of private health insurance coverage, managed care coverage, and Medicare coverage.

Medicaid identification cards are sent to recipients monthly. All identification cards are valid only through the end of the month in which they are issued. It is important that the provider or the designated agent check a recipient's identification card *prior* to providing service to determine recipient eligibility and limitations to the recipient's coverage.

If the recipient's identification card is held by the nursing home, it is the nursing home's responsibility to provide eligibility information to other providers of service.

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Medicaid identification cards are sent to recipients monthly. All identification cards are valid only through the end of the month in which they are issued. It is important that the provider or the designated agent check a recipient's identification card *prior* to providing service to determine recipient eligibility and limitations to the recipient's coverage.

If the recipient's identification card is held by the nursing home, it is the nursing home's responsibility to provide eligibility information to other providers of service.

C. Recipient Information (continued)

Nursing home residents who have Wisconsin Medicaid are allowed to retain a small portion of any pension or other income they may have. These retained funds are known as the recipient's *personal needs allowance* and are used, with the recipient's permission, or the permission of the recipient's legal representative, to pay for items or services not generally covered by Wisconsin Medicaid or routinely provided through the nursing home daily rate. This allowance is for items or services not typically provided but available, such as items preferred by the resident rather than the brand item provided by the home and services (e.g., beauty salon permanents). The personal needs allowance is set by Wisconsin statute and is currently $40 per month.

Any income in excess of the personal needs allowance is used to cover the recipient's cost of care in the nursing facility. This amount is known as *resident liability*. The fiscal agent deducts the resident liability amount from amounts due to the provider as part of claims processing. If the liability amount is incorrect for any reason, the nursing home should notify the agency which certified the recipient for Wisconsin Medicaid eligibility.

Section V of Part A of the provider handbook has detailed information on eligibility for Wisconsin Medicaid, identification cards, temporary cards, restricted cards, and how to verify eligibility. Providers should review Section V of Part A of the provider handbook before services are rendered. A sample identification card is in Appendix 7 of Part A of the provider handbook.

Eligibility/Authorization Report

Nursing homes receive a monthly eligibility/authorization report on all of the nursing homes' recipients who have been eligible or authorized for services during the previous 60 days. The report is printed by the fiscal agent following the printing of the identification cards, and is generally sent to nursing homes during the first week of each month. The report's information is valid for the month in which the report is received or dated, *not* for the previous month (e.g., a report dated 07/31/95 contains eligibility information for July 1995).

In addition to current eligibility information, the report also includes level of care (LOC) authorization and recipient liability information. Carefully review this report to avoid claim denials and incorrect payments. An example of an Eligibility/ Authorization Report form and the instructions are Appendices 13 and 14 of this handbook.

Care Level Determinations

Care level determinations for Medicaid recipients are made by the BQC. Care levels are determined at admission, when a resident becomes eligible for Medicaid benefits, and when the health care needs of the resident change. BQC reviews the recipient's care level annually.

Services are reimbursed when confirmation of care level determinations are received by the fiscal agent from the Division of Health, BQC. Medicaid care level codes are listed above under Nursing Home Reimbursement and in Appendix 15 of this handbook. If the nursing home bills before the care level is on file, the claim is denied. If the incorrect accommodation codes are used on the claim form, the claims will be denied pending proper care level verification through the Bureau of Quality Compliance.

BQC notifies the fiscal agent weekly to update the care level file. Nursing homes should contact the BQC if care level information is incorrect. Appendix 22 of this handbook contains the addresses of the BQC regional offices.

C. Recipient Information (continued)

Notice of Care Level Change

The Notice of Care Level Change is completed for Medicaid nursing home recipients whose care level is changed by the BQC staff. Nursing homes may request a care level review from the Division of Health regional office.

Nursing Home Discharges and Notification of Death

Providers must send notification of nursing home discharges and notifications of death to the recipient's certifying agency, such as the county which certified the recipient for Medicaid eligibility. The certifying agency is responsible for updating recipient information.

Nursing homes must notify the BQC regional office of all discharges and deaths of Wisconsin Medicaid recipients.

Notifications must include the:

- recipient name and Medicaid identification number;
- recipient date of birth;
- date of death or discharge; and
- nursing home's eight-digit Medicaid provider number.

Nursing homes must notify the BHCF within 30 days of a recipient's death if the DHSS' Estate Recovery Program applies (Refer to "Estate Recovery Program" in Section I of this handbook). When the Estate Recovery Program applies, the nursing home must send the "Estate Recovery Program Notification of Death" form in Appendix 28 of this handbook.

Documentation Requirements for ICF-MR or FDD Services

A physician must certify that ICF-MR services are needed. This certification is made at the time of admission, or if an individual applies for Wisconsin Medicaid while in a nursing home, before reimbursement can occur. Recertification by a physician must occur at periodic intervals after initial certification.

Individual Written Plan of Care - ICF-MR or FDD Services

Prior to initial admission to an ICF-MR, the attending physician must establish a written plan of care for each recipient. The plan of care must include:

- diagnoses;
- symptoms;
- complaints and complications indicating the need for admission;
- a description of the individual's functional level;
- objectives;
- any orders for medications;
- treatments;
- restorative and rehabilitative services;
- activities;
- social services and diet;
- plans for continuing care; and
- plans for discharge.

NOTE: The attending physician and other personnel involved in the recipient's care must review the plan of care at least every 60 days.

C. Recipient Information (continued)

Comprehensive Resident Assessment - NF and SNF

All nursing homes must enter a written comprehensive resident assessment in the recipient's record (according to HSS 132.60(8)(d), Wis. Admin. Code). Periodic reassessment is also required.

Any nursing facility that participates in the Medicaid or Medicare programs must use the resident assessment instrument specified by the state to assess all residents. Sections 1819 and 1919 of the Social Security Act specify assessment requirements for skilled nursing facilities for Medicare and nursing facilities for Medicaid, that provide nursing, medical, and rehabilitative care to Medicare and/or Medicaid beneficiaries. Section 49.498, Wis. Stats., includes the requirement for a resident assessment instrument.

These provisions require facilities to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity using a resident assessment instrument specified by the state. The resident assessment instrument consists of the minimum data set (MDS) and resident assessment protocols (RAPs). The MDS is a functionally based assessment tool; RAPs use MDS assessment information to identify potential problem areas for nursing home follow-up. RAPs also contain guidelines to help identify key causal or contributing factors to consider in developing, reviewing and revising a resident's care plan.

Appendices 23 and 24 of this handbook include the current, required MDS forms (effective January 1, 1996) for Medicaid nursing homes. More information, including a training manual and reference guide, for the resident assessment instrument is available from the BQC.

Nursing Home Pre-Admission Screening for Developmentally Disabled and Mentally Ill Recipients (PASARR)

The Omnibus Budget and Reconciliation Act of 1987 established resident review requirements for current and prospective nursing home residents. The requirements are called the Pre-Admission Screen/Annual Resident Review (PASARR). Wisconsin began implementation of the PASARR requirements on January 1, 1989. Nursing homes are notified of program changes through the DHSS' program memoranda.

PASARR - Purpose and Process

PASARR determines if a current or prospective resident is suspected of having a serious mental illness or a developmental disability and if the person is appropriate for nursing home placement. Nursing facilities may not admit individuals suspected of having a serious mental illness or a developmental disability until an assessment determines that the person needs nursing home placement and specialized services.

This process begins with a nursing home conducting a Level I screen prior to admission for *any* individual seeking admission. Appendix 25 of this handbook includes the Level I screening form. Based on the information collected from the Level I screen, an individual may also require a Level II screen. A Level II screen is required for all potential residents whose Level I screen indicates a possibility of major mental illness or a developmental disability. Level II screens must be conducted by the respective nursing facility's regional PASARR agency contracted by the Division of Community Services, Bureau of Community Mental Health.

C. Recipient Information (continued)

If a Level II screen is required, the Level I screener must notify their Regional PASARR Contractor. The contractor will perform the Level II screen and determine the appropriateness of nursing home placement and the need for specialized services. A person may not be admitted to a nursing home until the screening process is completed.

For further information on the Level II screening process, contact the DHSS Bureau of Developmental Disabilities at (608) 266-3717 or the Bureau of Community Mental Health at (608) 266-9316 or 266-7072.

Annual Resident Reviews (ARR)

Any resident with a serious mental illness or a developmental disability admitted to a nursing facility through the Pre-Admission Screening process must be re-screened on an annual basis. This is referred to as an Annual Resident Review (ARR). Annually is considered as occurring within every fourth quarter after the previous Level II screen or the previous ARR. The ARR can be performed only by the regional PASARR contractor.

PASARR Screening and Specialized Services Reimbursement

Nursing homes receive $30 for each Level I screen performed, regardless of the pay source of the recipient. Appendices 16 and 17 include the reimbursement request form and instructions.

Nursing homes are also eligible for a $9 per patient, per day supplement to the daily rate for individuals with a serious mental illness who have been determined by PASARR to require specialized services. This does not include private pay residents. The reimbursement supplement is only for days in which the resident is in the facility and receiving specialized services, excluding therapeutic and hospital bed-hold days. There is no supplement to the daily rate for the developmentally disabled residents due to other funding sources for specialized services, including the Medicaid nursing home formula.

Requirements for Specialized Services Reimbursement

To be eligible for specialized services reimbursement, the nursing facility must have a resident(s) determined by a Level II Pre-Admission Screen or by an ARR to need facility placement and require specialized services. The facility must submit an individualized Specialized Services Plan of Care to BHCF, Nursing Home Section. The nursing facility must submit a specialized services roster claim form monthly to the BHCF's Nursing Home Section. Appendix 26 of this handbook includes the specialized services roster claim form. Payments are made quarterly and are reflected on the nursing home's Remittance and Status Report by the Medicaid fiscal agent.

Nursing facilities must complete residents' ARRs within the calendar quarter in which they are due. Reimbursement will be withheld if the ARRs are past due. Reimbursement will be reinstated when the ARRs are completed and the specialized services determination date is updated on the roster claim form.

For further information on reimbursement, please contact the BHCF Nursing Home Section Analysis Unit.

C. Recipient Information (continued)

Managed Care Program Coverage

Wisconsin Medicaid managed care programs are developed principally for the Aid for Families with Dependent Children (AFDC) and Healthy Start population. There are a few pilot managed care projects for the elderly and disabled population. The emphasis is prevention, primary, and acute care services. Nursing home services *may* be included in the plan. Providers should be aware of managed care as an initiative of Wisconsin Medicaid, and should be aware that Medicaid recipients may be enrolled in contracted managed care programs. Managed care plans may include nursing home services subject to the conditions and terms of the individual plans themselves.

Medicaid recipients enrolled in Medicaid-contracted managed care programs receive a yellow Medicaid identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, 22, 22a, and 22b of Part A of the provider handbook.

Providers must always check the recipient's current Medicaid identification card for managed care program coverage before providing services. Claims submitted to the fiscal agent for services covered by Medicaid-contracted managed care programs are denied.

For recipients enrolled in a Medicaid-contracted managed care program, all conditions of reimbursement and prior authorization for nursing home services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, and hospitalizations is included in Section IX of Part A of the provider handbook.

Estate Recovery Program

According to s.49.496, Wis.Stats., the DHSS administers an estate recovery program as part of the Medicaid Program. The BHCF is the administering entity. The Wisconsin Estate Recovery Program (ERP) entails Medicaid collecting funds from the estate of a deceased Medicaid-nursing home recipient under certain conditions. The DHSS may recover funds from the estate of a deceased recipient if:

- the recipient has no surviving spouse; and
- no minor or disabled child.

The nursing home must notify the DHSS within 30 days of a resident's death if the above conditions apply by completing the "Estate Recovery Program Notification of Death" form. Refer to Appendix 28 of this handbook for a copy of this form.

If the DHSS is initiating an estate recovery action, the BHCF sends the nursing home an affidavit 20 days after the date of death. The affidavit claims the funds and advises the nursing home to transmit the funds to the DHSS. Refer to Appendix 27 of this handbook for a copy of the affidavit.

For additional information on the Estate Recovery Program, please contact the Coordination of Benefits Unit of the BHCF.

A. General Information

Covered nursing home services are medically necessary services provided by a certified nursing home to a nursing home recipient and prescribed by a physician in a plan of care.

Medicaid-certified nursing homes are called nursing facilities (NFs). Nursing homes which also participate in Medicare are called skilled nursing facilities (SNFs). Certified facilities, including distinct parts, which predominantly serve the developmentally disabled are called intermediate care facilities for the mentally retarded (ICF-MRs) or facilities for the developmentally disabled (FDDs).

Facilities that meet the federal definition of institutions that primarily accept and treat persons with mental illness are called institutions for mental diseases (IMDs). All facilities that meet the definition of an IMD are notified by the Department of Health and Social Services (DHSS). Wisconsin Medicaid does not cover any services provided to residents of an IMD who are between the ages of 21 and 64. This means that residents of an IMD between 21 and 64 are not eligible for Medicaid services, including all separately billable Medicaid services.

B. Services Reimbursed in the Nursing Home Daily Rate

For NFs and FDDs, Medicaid nursing home payment policies and principles are used and are contained in the annual nursing home payment formula or Methods of Implementation. The payment formula is an annual formula corresponding to the State Fiscal Year (July-June), and formula updates and modifications are generally effective each July 1.

The setting of rates for each certified-nursing home is the responsibility of Medicaid Regional Auditors. This includes setting interim rates (if applicable), rates for new operations, facility phase down rates, and final rates. Information on the formula with respect to individual nursing homes can be obtained by contacting the home's regional auditor. Appendix 21of this handbook contains the addresses of Medicaid Regional Auditors.

The payment formula must comply with federal law and regulations which state that Medicaid payments to nursing facilities "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable laws, regulations, and quality and safety standards...." (SSA 1902 (a)(13)(A)). The law further requires that the State (Medicaid) Agency "take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident...) of complying with (standards)" (SSA 1902 (a) (13) (A)).

Using this norm, the costs incurred by efficiently and economically-operated facilities for all routine, day-to-day health care services and materials provided to recipients by a nursing home are reimbursed in the daily rate. Every certified nursing facility has daily rates calculated for each accommodation code or care level served in the facility with the rate based upon a payment formula. Please refer to the annual Methods for further information and specifics on the formula.

According to HSS 107.09, Wis. Admin. Code, routine services and costs include:

1. nursing services;
2. special care services, including activities, therapies, recreation, social services, and religious services;

B. Services Reimbursed in the Nursing Home Daily Rate (continued)

3. supportive services, including dietary, housekeeping, maintenance, institutional and personal laundry services, but excluding personal dry cleaning services;
4. administrative and other indirect services;
5. physical plant, including depreciation, insurance, and interest on plant;
6. property taxes;
7. over-the-counter (OTC) analgesics and medically necessary non-covered OTC drugs;
8. non-medical transportation services (medical transportation is separately reimbursable; see the annual Methods for specific information);
9. services for developmentally disabled residents; and
10. supplies and equipment. This includes dietary supplies, incontinence supplies, personal comfort supplies, medical supplies and equipment, and other similar items. All of these items are associated with a recipient's personal living needs in normal and routine nursing home operations. Section 5.000 of the annual Methods of Implementation contains a list of these items.

Certain durable medical equipment (DME) and disposable medical supplies (DMS) are separately reimbursable for nursing home recipients. Please refer to the section below on DME/DMS, the DME (Part N) provider handbook, along with the DMS Index and DME Index for further information and specifics on DME and DMS. The DME (Part N) provider handbook and the Indices applies to all Medicaid recipients, including all Title XIX nursing home residents. The DME Index and DMS Index identify DME and DMS items included or excluded in the nursing home daily payment rate.

C. Ancillary Add-ons to the Nursing Home Daily Rate

Certain services that are normally billed separately from the nursing home daily rate may be included as an ancillary add-on to the nursing home daily rate. An add-on is for specifically-identified covered services and materials which could be billed separately to Wisconsin Medicaid by an independent provider of service. These services and materials must be available to all Medicaid recipients of the facility. If some portion of the services and materials must be supplied by an outside provider, the facility is responsible for payment to the outside provider.

Nursing homes need prior approval from Medicaid regional auditors for ancillary add-ons.

Nursing homes who request ancillary add-ons must be able to document that these services will cost no more than if they are billed separately, according to HSS 107.09(4)(1), Wis. Admin. Code. Nursing homes interested in ancillary add-ons should contact their Medicaid regional auditor.

D. Ancillary Services Reimbursable Beyond the Nursing Home Daily Rate

Ancillary services for nursing home residents are those which are considered non-routine and, thereby, not included in the nursing home daily rate. Certain covered ancillary services are separately reimbursable from the nursing home daily rate. The costs incurred for ancillary services are billed through ancillary codes.

Wisconsin Medicaid requires prior approval for ancillary services except medical transportation.

D. Ancillary Services Reimbursable Beyond the Nursing Home Daily Rate (continued)

For lab services (code "N3" below) and radiology/x-ray (code "N4" below), prior approval is required from the BHCF Nursing Home Section Regional Auditors. For the ventilator care, AIDS care and private room requests (codes "N6," "N7," and "N9" below), prior authorization is required from the BHCF Medicaid Audit Section.

Nursing home providers do not need separate Medicaid certification to provide ancillary services. In some cases, nursing homes may need to perform additional services to qualify for Medicaid ancillary coverage.

The valid ancillary services and their corresponding codes are:

N2 Transportation: This is medical transportation of a recipient to obtain health treatment or care. The treatment or care must be prescribed by a physician as medically necessary and must be performed at a physician's office, clinic, or other recognized medical treatment center. The nursing home must provide the transportation in its controlled equipment and by its staff, or by common carrier (e.g., bus, taxi). The charges are cost per mile, not staff cost. Billings may not exceed the nursing home's actual cost. Routine transportation to activities, such as social events, is part of the daily rate. For specialized motor vehicle transportation, please see *Wisconsin Medicaid Updates* on specialized motor vehicle transportation services.

N3 Laboratory Services.

N4 Radiology Services.

N6 Private Room: A private room may be prior authorized under certain medically necessary conditions for isolation per HSS 132 and Centers for Disease Control guidelines. Please contact the BHCF Medicaid Audit Section for more information on qualifying conditions. An approved private room rate is the facility's Wisconsin Medicaid rate plus the difference between the facility's daily private-pay semi-private room rate and private-pay private room rate up to $35. Documentation of the rate differential must accompany the prior authorization request.

N7 Ventilator Care: Wisconsin Medicaid provides additional reimbursement for ventilator dependent recipients admitted to nursing homes authorized to provide ventilator dependent care. The current ventilator rate is listed in the Nursing Home Methods of Implementation in Section 4.690.

N9 AIDS Care: A provider accepting recipients with a diagnosis of AIDS may receive additional reimbursement for the recipient. The current AIDS rate is listed in the Nursing Home Methods of Implementation in Section 4.690.

E. Other Ancillaries

Other Ancillaries

Nursing facilities may bill other ancillary services that do not have "N" codes, subject to BHCF approval. For example, certain supplies and equipment for tracheostomy care and exceptional supply needs for ventilator dependent patients and patients receiving similar care. Other supplies and equipment may be reimbursable to a nursing facility separate from the daily rate without prior authorization and billed on the HCFA 1500 claim form. Supplies and equipment listed in Sections 6.310 and 5.160 may be reimbursed separate from the daily rate subject to prior authorization. Supplies listed in Sections 5.110-5.150 are included in the daily rate. For identification of specific items of equipment and supplies to determine whether the items are in the daily rate or separately billable, please refer to the DME Index and DMS Index. Please see Sections II-I and II-J, along with Section III on prior authorization for additional information.

F. Nursing Home Head Injury Patients

Nursing Home Head Injury Patients

According to Section 4.692 of the Nursing Home Methods, approved facilities providing specialized treatment for head injuries may receive a negotiated rate, in lieu of the facility's daily rate, for each resident participating in the head injury program. Allowable cost principles and formula maximums may be applied to rate calculations. Rates are all-inclusive, including all durable medical supplies and exceptional supplies. Rates further include bedhold. Rates may be updated periodically to account for changes in facility costs. The treatment program must be approved by the Department of Health and Social Services (DHSS) based on established criteria for admission, continuing stay, discharge and other program requirements as determined by the DHSS.

Treatment program and rates must be appropriate and receive prior approval of the BHCF Medicaid Audit Section and Nursing Home Section. Effective July 1, 1994, the billing for such treatment was converted from an ancillary billing to an accommodation code. Refer to Section I-B of this handbook for a listing of accommodation codes.

Facilities interested in the program requirements and information for treatment of head injured persons should contact:

Director
Bureau of Health Care Financing
P.O. Box 309
Madison WI 53701-0309

G. Services Provided by Other Providers

Generally, when a billable, covered service is provided to a Medicaid nursing home resident by an independent provider of service (e.g., dentist outside of the nursing home), reimbursement may be claimed only by the independent provider under the independent provider's number. Medicaid certification and program requirements for that provider type apply.

H. Bedhold

General Information

Bedhold is covered for therapeutic leaves of any length and for hospital stays up to 15 days. Payment will only be made if the nursing home meets the requirements of the qualifying criteria. Specific bedhold requirements are communicated in BQC program memoranda. The nursing home must have an occupancy threshold of 95 percent for the previous month or have had eight vacant beds or less in the previous month to qualify for Medicaid bedhold coverage. Accommodation codes for billing hospital bedhold charges or therapeutic leaves are in Appendix 15 of this handbook.

Bedhold Days for Hospital Visits

Hospitalization bedhold days are reimbursable for up to 15 days per hospital stay. There is no limit on the number of stays per year. Beyond 15 days, hospital bedhold is a noncovered service.

1. The first day that the recipient leaves the nursing home, regardless of the time of day, is the first day the recipient is considered absent. The day the recipient returns to the nursing home does not count as a bedhold day, regardless of the time of day.

2. All hospital bedhold days up to 15 days are considered covered services ; therefore, bedhold charges to the recipient, family, or friends are prohibited. No resident or third party may be charged for covered, bedhold days for a Wisconsin Medicaid recipient. With the prior consent of the recipient or a legal representative, bedhold may be charged to hold the bed after 15 days of Medicaid-covered hospital, bedhold services.

H. Bedhold (continued)

3. Recipients cannot be administratively discharged from the nursing home unless they remain in the hospital longer than 15 days and no agreements have been made to hold the bed through payments by the resident, family or guardian and the resident and legal representative or family have been given a 30 day notice of involuntary discharge through the federal requirements for discharge under 42 CFR 483.12.

4. Claims for bedhold days during leaves for hospitalization cannot be submitted when it is known in advance that a recipient will not return to the nursing home following the hospital stay.

Providers can claim only the days prior to:

- the recipient's return to the nursing home;
- the recipient's death in the hospital;
- notification of the recipient's terminal condition; or
- the recipient's need for discharge to another facility.

Bedhold Days for Therapeutic Visits

Therapeutic visits are overnight visits (one or more nights) by a recipient with relatives or friends. Bedhold days for therapeutic visits are reimbursable if the recipient requests leave days for visits, and if the recipient's physician approves the leave in the physician's plan of care for the recipient. This statement must include the rationale for and the anticipated goals of the leave, as well as any limitations on the frequency or duration of leaves. The provider must note any time there is a change in the recipient's condition in the plan of care. The following information also applies to bedhold days for therapeutic visits:

1. The first day that the recipient leaves the nursing home, regardless of the time of day, is the first day the recipient is considered absent. The day the recipient returns to the nursing home does not count as a bedhold day, regardless of the time of day.

2. All therapeutic leaves of absence for visits are considered covered services until determined otherwise. Bedhold charges to the recipient, family, or friends are prohibited.

3. Bedhold days for a therapeutic visit leave, when it is known in advance that a recipient does not plan to return to the facility following the therapeutic visit, are not covered under Wisconsin Medicaid.

4. A staff member designated by the administrator (e.g., social service director or nursing service director) must document the recipient's absence in the recipient's records and approve each individual leave based upon physician order(s).

Bedhold Days for Therapeutic/Rehabilitative Programs

Bedhold days for therapeutic or rehabilitative programs are covered when:

1. The therapeutic/rehabilitative program, in the opinion of the recipient's physician, contributes to the recipient's mental, physical, or social development according to the recipient's plan of care. The program must meet the definition of a therapeutic or rehabilitative program:

H. Bedhold (continued)

"A formal or structured medical or health care activity which is designed to contribute to the mental, physical or social development of its participants, and is certified or approved, or its sponsoring group is certified or approved, by a national standard-setting or certifying organization when such an organization exists." (HSS 101.03[165], Wis. Admin. Code)

2. Upon request from Wisconsin Medicaid, the nursing home must submit in writing the following information regarding the recipient:

   - dates of the program's operation;
   - number of participants;
   - identification of the program's sponsorship;
   - anticipated program goals and how the goals will be accomplished (treatment modalities); and
   - the program's leadership or faculty and their credentials.

3. Each time the recipient attends a therapeutic or rehabilitative program, the recipient's physician must include:

   - a written statement in the plan of care approving for the recipient's participation in the program;
   - the goals of the program which apply to the recipient; and
   - the duration or frequency of the recipient's participation.

4. The first day that the recipient leaves the nursing home, regardless of the time of day, is the first day the recipient is considered absent. The day the recipient returns to the nursing home does not count as a bedhold day, regardless of the time of day.

5. Leaves of absence to attend therapeutic or rehabilitative programs are considered covered services until determined otherwise. Bedhold charges to the recipient, family, or friends are prohibited.

6. A staff member designated by the administrator (e.g., director of nursing service or social service director) must document the recipient's absence in the recipient's chart.

7. The bedhold for therapeutic/rehabilitation programs cannot be claimed if the recipient is receiving these services at another in-state or out-of-state nursing home.

8. There is no limitation on bedhold days for therapeutic/rehabilitation leave as long as all other criteria are met.

For additional information on bedhold policies, such as resident transfer and discharge rights requirements and Medicare Part A implications for bedhold, please refer to the BQC Memoranda on this subject. Copies of BQC Memos can be obtained directly from the BQC.

I. DME and Wheelchairs Provided to Nursing Home Recipients

General Information

DME and wheelchairs reasonably associated with a patient's personal living needs in normal and routine nursing home operations are to be provided to Wisconsin Medicaid recipients without charge to the recipient, the recipient's family, or other interested persons. The cost of all wheelchairs, including geriatric chairs but excluding motorized wheelchairs or vehicles, is included in the nursing home payment rate. All items must be suitable for use in the recipient's place of residence.

I. DME and Wheelchairs Provided to Nursing Home Recipients (continued)

Most DME is reimbursed through the nursing home daily rate. Certain DME is separately reimbursable for nursing home recipients. Some DME requires prior authorization, and some DME can be billed separately from the daily rate without prior authorization.

Wheelchairs Reimbursable Through the Nursing Home Daily Rate

All manual wheelchairs without a custom adaptive positioning system are reimbursable through the nursing home daily rate.

Wheelchairs Separately Reimbursable and Not Included in the Nursing Home Daily Rate

Under certain conditions, manual wheelchairs with a custom adaptive positioning system, and all power/motorized wheelchairs are not included in the nursing home daily rate. Also repairs of a resident-owned power wheelchair or a wheelchair with a custom adaptive positioning system are reimbursed separately by Wisconsin Medicaid. Repairs over $150 require prior authorization. This topic is addressed in more detail in Sections II-D, II-J, and III-H of the Part N DME Handbook and its updates.

DME and Wheelchairs

Under certain conditions, DME and wheelchairs may be billed separate from the nursing facility payment rate with prior authorization. Nursing homes can bill directly or use a certified DME provider to bill certain DME. Please see Section II-J of the DME (Part N) provider handbook for information on this topic and the DME Index for identification of which DME items are in the rate and which can be billed separately. *Wisconsin Medicaid Updates* on DME and wheelchairs provide current information on this topic.

Separate payment for certain DME may be allowed if the DME is personalized or custom-made for a recipient resident and is used by the resident on an individual basis for hygienic or other reasons. Some of these items require prior authorization and some do not. These items include, but are not limited to, orthoses (see Part N, Section II-F), prostheses (including hearing aids) (see Part N, Section II-H and the Wisconsin Medicaid audiology handbook), orthopedic or corrective shoes (see Part N, Section II-G), and pressure relief beds (see Part N, Section III-B). Please see Sections II and III of the DME (Part N) provider handbook and the DME Index for covered services and prior authorization policies for DME for nursing home residents.

According to HSS 107.09(4), Wis. Admin. Code, the following items are not included in calculating the daily nursing home rate but may be reimbursed separately: oxygen in liters, tanks, or hours, including tank rentals and monthly rental fees for concentrators (see Part N, Sections II-J and III-H); and tracheostomy and ventilatory supplies and related equipment, subject to guidelines and limitations published by the DHSS. The guidelines and limitations are contained in the DME (Part N) provider handbook, Section II-J, *Wisconsin Medicaid Updates*, and the DME Index.

DME and DMS exceptions to the daily rate (e.g. oxygen and supporting respiratory equipment), are billed on the HCFA 1500 claim form. Please see Section IV of this handbook for information on claims submission.

J. DMS Provided to Nursing Home Recipients

General Information

DMS are generally included in the daily rate for nursing homes and are not separately reimbursable. A provider may receive separate payment for DMS provided to a nursing home recipient under only these circumstances:

1. If recipients specifically elect to purchase DMS (other than nursing home stock items) with their personal allowance. This is only for DMS that is considered not medically necessary.
2. If recipients are eligible as a result of their medical conditions to receive exceptional supplies. Under this situation, prior authorization is required. Please see The DME (Part N) provider handbook, Section II-J for further information.
3. If the DMS items are identified on the DMS Index as not included in the nursing home rate but separately reimbursable on the HCFA 1500 claim form.

The DMS Index, as updated, provides the list of DMS with an identification of whether the supplies are included, or not included, in the daily rate. Nursing facilities automatically receive copies of, and updates to, the DMS Index.

K. Medically Necessary Noncovered Services

Resident Liability

Under Wisconsin Medicaid, resident liability refers to the amount of resident income which is available, according to recipient eligibility criteria, to apply on a monthly basis towards monthly cost of care. The resident liability reduces the amount paid by Wisconsin Medicaid.

General Information

Some medically necessary services are not covered by Wisconsin Medicaid for nursing home recipients. However, it is possible to have the costs for these services identified and deducted from the resident liability amount. The resident liability amount is the amount of recipient income that is available to apply toward the cost of care. In addition, there is a personal needs allowance for resident's personal needs which may be used to pay for Medicaid noncovered, nonmedically necessary items and services under certain conditions. This is not part of the resident liability. See Section II-M of this handbook for more information.

Federal regulations state that only medically necessary noncovered services may be charged against the liability without the resident's consent and allow Wisconsin Medicaid to establish reasonable limits on the necessary noncovered medical services which can be charged against the resident liability.

Items and Services That May Be Charged Against the Resident Liability

The following noncovered services have been determined to be medically necessary and are the only noncovered services that may be charged against the resident liability. These items and services may *not* be charged against the personal needs allowance.

1. Noncovered services or items from the following specific sections of HSS 107 Wis. Admin. Code.

HSS	*Service Area*	*Noncovered Services*
107.20(4)	Vision	a. anti-glare coating

K. Medically Necessary Noncovered Services (continued)

107.07(4)	Dental	a. fluoride mouth rinse b. panoramic radiographs which include bitewings c. professional visits, other than for the annual examination of a nursing home resident d. dispensing of drugs e. surgical removal of erupted teeth, except as otherwise stated in sub(3) f. alveoplasty and stomatoplasty g. bitewing x-rays, except as otherwise stated in sub(3)
107.24(5)	Durable Medical	a. foot orthoses or orthopedic or corrective shoes for the conditions listed in HSS 107.24(5)(a)

2. Eyeglass frames or lenses beyond the original pair and one unchanged prescription replacement pair from the same provider in a 12-month period which have been denied through prior authorization by Wisconsin Medicaid.

3. For dental services, recent budget changes have made the following dental services noncovered services, specifically, complete and partial dentures, denture relines, denture repairs and fixed prosthodontics.

Enter noncovered services charged against the resident liability on the UB-92 claim form. The dollar amount applied against the resident liability reduces the amount paid by Wisconsin Medicaid. The liability amounts are shown using the billing codes in Section II-L of this handbook.

L. Codes for Medically Necessary Noncovered Services

Noncovered, medically necessary, physician-prescribed services and items must be included on the UB-92 claim form. The appropriate codes are listed below. The resident liability must be used to pay for these items or services. If there is resident liability, it must first be exhausted before the personal needs allowance or family personal funds may be considered to pay for these items. (Refer to Section II-M below for more information.) The codes are:

M6 - Noncovered vision services
M7 - Noncovered dental services
M8 - Other noncovered services

These are the only valid codes to use for this purpose.

M. Nonmedically Necessary Noncovered Services

Personal Needs Allowance

The recipient may be financially responsible for certain noncovered items and nonmedically necessary services. A portion of a resident's funds, as prescribed in 42 CFR 483.10, is available for a living allowance or personal needs allowance. This allowance may be used to pay for certain Medicaid noncovered items and services. The recipient can choose to apply the allowance to obtain certain noncovered services and items, such as personal comfort items not included in the nursing facility payment rate. Resident personal funds cannot be used without the prior written consent of the recipient. The personal needs allowance is set by s.49.45(7)(a), Wis. Stats. and is currently $40 per month.

M. Nonmedically Necessary Noncovered Services (continued)

Private Rooms

Private rooms are not a covered service in a nursing home's daily reimbursement rate, except for medically-necessary isolation precautions. However, if a recipient, or a recipient's legal representative, chooses a private room with the full knowledge and acceptance of the financial liability, the recipient may reimburse the nursing home for a private room under the following conditions:

- the recipient or a legal representative is informed of the personal financial liability if the recipient chooses a private room;
- pursuant to HSS 132.31(1)(d) Wis. Admin. Code, the recipient or a legal representative documents the private room choice in writing;
- the recipient or a legal representative is personally liable for no more than the difference between the nursing home's private-pay rate for a semi-private room and the private-pay, private room rate; and
- if at any time this differential rate changes, the recipient or a legal representative must be notified by the nursing home administrator within 15 days and a new consent agreement must be reached.

A. General Requirements

According to HSS 107.02(3), Wis. Admin. Code, Wisconsin Medicaid requires prior authorization for certain services in order to:

- safeguard against unnecessary or inappropriate care and services;
- safeguard against excess payment;
- assess the quality and timeliness of services;
- determine if less expensive alternative care, services, or supplies are usable;
- promote the most effective and appropriate use of available services and facilities; and
- curtail misutilization practices of providers and recipients.

Providers need prior authorization for certain specified services *before* delivery, unless the service is an emergency. Payment is not made for services provided either before the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider provides a service which requires prior authorization without first obtaining authorization, the *provider* is responsible for the cost of the service.

B. Services Requiring Prior Authorization

The following nursing home services require prior authorization:

1. Nursing home accommodation services billed at a level of care other than the authorized level of care recorded on the recipient eligibility file.
2. Specialized wheelchairs to meet the specialized needs of nursing home recipients.
3. The ventilator reimbursement rate for ventilator-dependent recipients who are being admitted to approved nursing homes and for whom nursing homes request the ventilator reimbursement rate.
4. Reimbursement for Medicaid AIDS rate, including private room accommodation for an AIDS resident when medically necessary.
5. Exceptional supplies for tracheostomy and ventilator dependent residents or residents receiving similar care meeting the criteria in Section II of the DME (Part N) provider handbook.
6. Head injury care at the negotiated Medicaid head injured rate.
7. Payment for a medically necessary private room.
8. Other Medicaid covered services requiring prior authorization regardless of place of residence, e.g. therapy visits beyond 35 visits per spell of illness and for conditions meeting the criteria in Section III of Wisconsin Medicaid therapies handbooks.
9. Certain Durable Medical Equipment (DME), including certain wheelchairs.

DME and Wheelchairs

DME and wheelchairs reasonably associated with a patient's personal living needs in normal and routine nursing home operations are to be provided to Medicaid recipients without charge to the patient, the patient's family, or other interested persons.

B. Services Requiring Prior Authorization (continued)

Under certain conditions, DME and wheelchairs may be billed separately if prior authorized. The prior authorization request must document the need for the item according to the exception criteria described below. According to the Medicaid State Plan, separate payment for DME may be allowed with prior authorization by the Department of Health and Social Services (DHSS) if the DME is personalized or custom-made for a recipient resident *and* is used by the resident on an individual basis for hygienic or other reasons. Examples of such items include respiratory equipment and supplies, orthoses, prostheses (including hearing aids), orthopedic or corrective shoes, and pressure relief beds. Since some of these items may be billable separately without prior authorization, nursing homes should review the DME Index and DMS Index to identify which items are included in the rate, which can be billed separately, and which require prior authorization.

Special Adaptive Positioning or Electric Wheelchairs

The DHSS may permit separate payment for a special adaptive positioning or electric wheelchair, while a recipient resides in a nursing home, if the wheelchair is prescribed by a physician and the following criteria are met:

1. The wheelchair is personalized in nature and is custom-made for a patient *and* is used by the resident on an individual basis for hygienic or other reasons; and
2. The special adaptive positioning wheelchair or electric wheelchair is justified by the diagnosis and prognosis and the occupational or vocational activities of the recipient (i.e. educational, therapeutic involvement).

Exceptions for wheelchairs may be allowed for the recipient who is about to transfer from a nursing home to an alternate and more independent setting.

DME - General Information

Information regarding DME and wheelchairs is contained in HSS 107.24, Wis. Admin. Code, and in the DME (Part N) provider handbook and DME Index. The Index lists which DME items require prior authorization.

Providers are advised that prior authorization *does not* guarantee payment. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other Medicaid requirements, must be met before the claim is paid.

Please refer to the DME (Part N) provider handbook, the DMS Index and the DME Index for DMS and DME covered services, identification of which items require prior authorization, prior authorization guidelines, and billing instructions for such items.

Medicaid-certified nursing facilities receive pertinent publications (updates, revisions, etc.) of the DME (Part N) provider handbook, including the DMS and DME indexes. If a nursing facility does not have the DME (Part N) provider handbook or the DMS or DME Index and wishes to obtain these publications, the facility should contact the fiscal agent.

C. Procedures for Obtaining Prior Authorization

Section VIII of Part A of the provider handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

Examples of the appropriate prior authorization request forms along with completion and submittal instructions are in Appendices 5 through 10 of this handbook.

C. Procedures for Obtaining Prior Authorization (continued)

Completed prior authorization request forms must be submitted to:

EDS
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Prior authorization request forms can be obtained by writing to:

EDS
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

A. Coordination of Benefits

Wisconsin Medicaid is the payer of last resort for any Wisconsin Medicaid-covered service. If the recipient is covered under health insurance and Medicare, Wisconsin Medicaid pays that portion of the allowable cost remaining after exhausting all health insurance sources. Refer to Section IX of Part A of the provider handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

B. Medicare/Medicaid Dual Entitlement

Recipients covered under both Medicare and Wisconsin Medicaid are dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare *before* billing Wisconsin Medicaid. Nursing homes do not have to be Medicare-certified to bill Medicare for some services. It is the responsibility of the nursing home to ensure correct and accurate billing systems.

Coinsurance days for dual entitlees are a covered service by Wisconsin Medicaid. All coinsurance claims automatically cross over from the Medicare program for Wisconsin Medicaid processing. Co-insurance days are billed using the UB-92 claim form. A UB-92 claim form sample and billing instructions are in Appendices 1 and 2 of this handbook.

A Medicare disclaimer code must be indicated on the claim, if the recipient has Medicare. Refer to the claim form instructions in Appendix 1 of this handbook for Medicare disclaimer codes.

C. Medicare QMB-Only

Qualified Medicare Beneficiary (QMB)-only recipients are only eligible for Wisconsin Medicaid payment of the coinsurance and the deductibles for the Medicare-covered services. (Since Medicare covers nursing home care, claims submitted for QMB-only recipients are reimbursed.)

D. Billed Amounts

Providers must always bill Wisconsin Medicaid their rate(s) established by Wisconsin Medicaid. In the case of retroactive eligibility, when the provider receives Medicaid payment, the nursing home must reimburse the recipient, family, or others the full amount paid for the period covered by Medicaid if such payments were made.

E. Copayment

Nursing home residents with a nursing home medical status code are exempt from any copayment charges.

F. Claim Submission

Paper Claim Submission

Nursing home services, including accommodation and billable ancillary services, must be submitted using the UB-92 claim form. Nursing home crossover claims must also be submitted on the UB-92 claim form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Nursing homes billing Wisconsin Medicaid for exceptional supplies, oxygen, durable medical equipment (DME), disposable medical supplies (DMS), and therapies must use the national HCFA 1500 claim form. A sample of the HCFA 1500 claim form and completion instructions are in Appendices 3 and 4 of this handbook.

Ordering Claim Forms

The UB-92 and HCFA 1500 claim forms are not provided by Wisconsin Medicaid or the fiscal agent. They may be obtained from a number of forms suppliers. One source for UB-92 claim forms is:

Standard Register
Post Office Box 6248
Madison, WI 53716
(608) 222-4131

HCFA 1500 claim forms may be obtained from:

F. Claim Submission (continued)

State Medical Society Services
P.O. Box 1109
Madison, WI 53701
(608) 257-6781 (Madison Area)
1-800-362-9080 (Toll-free)

Completed claims submitted for payment must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Paperless Claim Submission

The fiscal agent is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and will be subjected to the same processing requirements as paper claims. Providers submitting electronically can usually reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

G. Nurse Aide Training Payments

Requests for Reimbursement of Nurses Aide Training and Competency Testing

All nurse aides employed by a nursing home must be included on the Nurse Aide Registry maintained by the Bureau of Quality Compliance (BQC) within four months of the date of hire by the nursing home. New aides must meet specific training requirements and pass a competency evaluation before they can be included on the registry. Complete information on training and testing of new aides, and those aides currently listed on the registry, is available from the BQC.

Wisconsin Medicaid separately reimburses nursing facilities (NFs) for the cost of training and competency testing. This includes training and testing provided through any BQC approved programs. Wisconsin Medicaid reimburses training and testing once for each aide, unless the aide has not worked in a nursing or nursing related capacity for more than two years. In this situation, the aide must be retested. Wisconsin Medicaid reimburses providers for this cost and only after the aide is listed on the registry.

The cost of training and testing of nurse aides in Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) is not eligible for separate reimbursement because these costs are covered in the ICF-MR daily rate.

By federal law, nurse aides are not to bear any cost of training or testing. Therefore, nursing homes that hire aides who have, within the last 12 months, independently completed a training program, must reimburse the aides for the training and testing expenses. Payment must be made within 12 months of hire. Wisconsin Medicaid reimburses nursing homes for this cost through the "Nurse Aide Training and Competency Evaluation Reimbursement Request" form.

G. Nurse Aide Training Payments (continued)

Reimbursement for nurse aide training and competency testing must be claimed on a "Nurse Aide Training and Competency Evaluation Request" form, available from the fiscal agent. Copies of the reimbursement request form and complete billing instructions are included in Appendices 18 and 19 of this handbook. Reimbursement for training and testing of nurse aides is made quarterly. Reimbursement requests should be sent to the fiscal agent. Reimbursement is reflected as a "lump sum" cash payout on the facility's Remittance and Status Report. Payments are made within two weeks following a calendar quarter. A separate statement listing both the payments and denials is mailed to providers following each payment cycle. Providers may resubmit denied reimbursement requests for a subsequent payment cycle after correcting the erroneous information on the reimbursement request form.

For additional information regarding the reimbursement for nurse aide training, please contact the BHCF's Nursing Home Section.

For additional information regarding nurse aide training and the registry, please contact:

Nurse Aide Training and Registry Unit
Bureau of Quality Compliance
PO Box 2569
Madison, WI 53701-2569
(608)-267-2374

H. Diagnosis Codes

All diagnoses must be from the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM) coding structure. Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book can be ordered from:

ICD-9-CM
Post Office Box 991
Ann Arbor, MI 48106

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to Wisconsin Medicaid.
- Codes with an "M" prefix are not acceptable on a claim submitted to Wisconsin Medicaid.

I. Procedure Codes

All paper claims submitted to Wisconsin Medicaid must include procedure/accommodation codes. Claims received without the appropriate procedure codes are denied. Refer to Appendices 15 and 20 of this handbook for valid Wisconsin Medicaid accomodation and ancillary codes for use with the UB-92 claim form.

J. Follow-Up to Claim Submission

It is the provider's responsibility to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid or denied. Providers are advised that EDS takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A of the provider handbook includes detailed information regarding:

J. Follow-Up to Claim Submission (continued)

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.

NOTE: All claims for services rendered to Wisconsin Medicaid-eligible recipients must be received by the fiscal agent within 365 days from the date such service was rendered.

Retroactive Rate Adjustments

When nursing facilities have rate changes that affect previously paid claims, the fiscal agent processes retroactive rate adjustments on the paid claims. Retroactive rate adjustments are processed once a month after the nursing facility receives a letter notifying them of the rate change.

Retroactive rate adjustments will either increase or decrease the previously paid claim amount, depending on the revised rate. If money is being recouped with the adjustment, the provider has 30 days to send a check for the outstanding amount or to instruct the fiscal agent to recoup monies from future payments. If the provider takes no action in 30 days, the fiscal agent will automatically recoup 100 percent of the amount paid on each Remittance and Status report until the outstanding amount is satisfied.

Send payments to:

EDS
ATTN: Cash Unit
6406 Bridge Road
Madison WI 53784